TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
JAMES TANNER, DC

**Respondent Name**
GREAT AMERICAN ALLIANCE INSURANCE

**MFDR Tracking Number**
M4-14-1932-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
MARCH 3, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We have received notification that this functional capacity evaluation was denied. The first reason sates that precertification was absent. Functional capacity evaluations do not require precertification if they are less than the first three. This was the initial…As far as the medical necessity aspect of this. We get substantial information from a functional capacity evaluation including information that helps us determine what the patient's functional ability is. Often times we use this information to administer programs such as work hardening."

**Amount in Dispute:** $880.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Please see the EOBs provided as part of the requestor's filing and/or attached hereto. Requestor has incorrectly filed this as a medical fee dispute. Carrier denied the bill on the basis that the services were not medically necessary base on a peer review."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 20, 2013 | CPT Code 97750-FC (16 units)<br>Functional Capacity Evaluation (FCE) | $880.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.

3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §134.600, effective May 2, 2006,requires preauthorization for specific treatments and services.
5. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
6. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - 776-Services exceeding ODG WC treatment guidelines in frequency or duration require preauthorization. No preauthorization noted.
   - 95-Plan procedures not followed.
   - U02-The billed service was reviewed by UR and denied.
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation.
   - 270-NO allowance has been recommended for this procedure/service/supply please see special *NOTE* below. Re-evaluation claim was denied per client's instruction due to FCE is not medically necessary per ODG. Therefore, we are unable to recommend any additional allowance at this time.
   - U02-The billed service was reviewed by UR and denied.

**Issues**

1. Does a preauthorization issue exist in this dispute?
2. Does a medical necessity issue exist in this dispute? Is the dispute eligible for medical fee dispute resolution?

**Findings**

1. According to the explanation of benefits, the carrier denied reimbursement for the disputed FCE based upon a lack of preauthorization.

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   The requestor billed CPT code 97750-FC for the diagnosis 847.2-lumbar sprain/strain.

   According to the Fitness for Work Section Chapter of the Official Disability Guidelines (ODG), an FCE is recommended treatment for a lumbar sprain/strain; therefore, the disputed FCE does not require preauthorization.

2. Based upon the reconsideration explanation of benefits, the respondent denied reimbursement for the disputed FCE based upon a lack of medical necessity.

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury." 28 Texas Administrative Code §133.305(b) requires that "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021." 28 Texas Administrative Code §133.307(e)(3)(B) states "Dismissal. A dismissal is not a final decision by the division. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section. The division may dismiss a request for MFDR if: (B) the request contains an unresolved adverse determination of medical necessity." The appropriate dispute process for unresolved issues of medical necessity is pursuant to 28 Texas Administrative Code §133.308

prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that a medical necessity issue exists, therefore, the dispute was not filed in accordance with 28 Texas Administrative Code §133.305 and §133.307.

The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 06/10/2015<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.